MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Dr. B 7125 Marvin D. Love #107 Dallas, TX 75237	MDR Tracking No.: M4-03-3871-01 TWCC No.: ___ Injured Employee's Name: ___
Respondent's Name and Address Dallas I.S.D. Box 42	Date of Injury: ___ Employer's Name: ___ Insurance Carrier's No.: 2002029599

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
01/28/03	01/28/03	97799-JA	$400.00	
04/10/03	04/10/03	99213	$9.60	

PART III: REQUESTOR'S POSITION SUMMARY

Position Statement dated 11/14/03 states in part, "…Our charge for date of service was partially made due to an incorrect negotiated contract; we attached a letter from the company stating that Wol-Med does not participate in this program. For date of service 1-28-03 our Job Assessment was denied stating that the evaluator was not licensed, we attached the examiners license…"

PART IV: RESPONDENT'S POSITION SUMMARY

Position Statement dated January 2, 2004 states in part, "… Carrier has previously responded to this dispute on 12/19/2003. As Carrier indicated, it has neither denied nor paid any billing for date of service 2/13/2003 as it never received any bills from the requestor…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

CPT Code 99213 for date of service 02/13/03. EOBs were not submitted by either party. Although the requestor submitted a "demand letter" and a copy of a "Track & Confirm" from USPS, the submitted documentation does not confirm that the correct carrier received the request for reconsideration. A copy of the signed green card was not submitted; therefore, per Rule 133.307(e)(2)(B) the requestor did not submit convincing evidence that the respondent received the request for reconsideration. Reimbursement is not recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
				Total Left Column:			$0.00
				Total Amount Due:			$0.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to reimbursement.

Ordered by:

	Marguerite Foster	01/31/05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____